Background to the trial of Prof Tim Noakes and his letter to the University of Cape Town

By Prof Tim Noakes

On June 8th 2018 my trial before the Health Professions Council of South Africa (HPCSA) finally came to an end. After 28 days in court, tens of millions of rands spent in total by both parties to the dispute, and before two separate HPCSA committees, I was found innocent of all charges, bringing the toughest 4 and a half years of my life to a close.

The full story of those 4 and a half years including all the details of the HPCSA trial and the academic mobbing that preceded it, is laid out in great deal in the book that investigative journalist Marika Sboros and I wrote and published as *Lore of Nutrition*: *Challenging Conventional Dietary Beliefs* (South African edition) and *Real Food on Trial: How the Diet Dictators Tried to Destroy a Top Scientist* (International Edition).

I had hoped that the University of Cape Town and especially its Faculty of Health Sciences would apologize to me for the part a number of its staff played in my prosecution and academic mobbing during those 4 and a half years. All I really expected was a brief statement to the effect that the University acknowledged that I had been found innocent of all charges and that, in the course of the trial, I and my three expert witnesses had presented evidence to show that the diet we promote is both evidence-based and not unconventional.

But it has become increasingly apparent that neither the University nor its Faculty of Health Science is prepared either now or ever in the future to even consider such an apology. I believe that this decision comes from the very highest offices of the University of Cape Town and its oversight bodies.

Accordingly with the assistance of my wife, Marilyn, I chose to write a final statement to the Acting Dean of the Faculty of Health Sciences to explain how we now view our future relationship the University of Cape Town and especially its Faculty of Health Sciences.

The essence of the letter is included here. There were some issues that are private to the Faculty and are not for public display. These have been edited from the original.

The idea that we should make the letter public was advanced by Dr Zoe Harcombe PhD, one of the three expert witnesses who stood by Marilyn and me during the trial. She indicated that, as a female former PhD scientist who had in the past and who continues to experience similar targeting, especially the issue of academic mobbing needs to be more widely exposed wherever and whenever it happens.

The appropriately edited letter is the following:

Letter to University of Cape Town Faculty of Health Sciences December 2018.

As someone who has been around this Faculty since 1969 (i.e. for 50 years), I would like to make some comments of what I have learned during that time.

1. Institutional Culture

The first successful human heart transplant performed by Professor Christiaan Barnard in December 1967 motivated me to study medicine at UCT. Barnard was potentially the most important asset either UCT or the Faculty ever had. In the end Barnard failed the Faculty and the Faculty failed Barnard and, as a result, the promised potential he embodied was never realized.

I have a great interest in what makes successful sporting teams and at different times, have worked with some that became the best in the world.

The key to successful sporting teams is that they develop a "culture" of what they jointly strive for, what they believe and how they act, that ultimately makes success almost inevitable. Had the Faculty been a sports team with such an established culture, Barnard would have brought great honor to UCT and the Faculty over many years. Because that culture would have accommodated his weaknesses and channelled his strengths for the benefit of the "team"; that is UCT and the Faculty.

But because the Faculty (and UCT) in 1968 may not have had such a culture, Barnard was not properly managed and directed to his and the Faculty's benefit; his personal failings eventually dragged him down and the Faculty turned against him, fueled by the envy and jealousy of key personnel.

The key is that a culture is not what is said in lofty and lavish public pronouncements; it is what is practiced on a daily basis. The culture is what we experience on a day-to-day basis. We live it; we feel it; it cannot be faked. It is there all the time. It acts as much in the subconscious as in the conscious.

The untimely and tragic deaths by suicide of Professor Mayosi and the Faculty secretary Brenda Klingenberg, the premature resignation of Professor Vanessa Burch and the manner in which I was treated after 2012 (as described in detail in *Lore of Nutrition/Real Food on Trial*) identifies one worrying aspect of what may be a prevailing sub-culture within this Faculty (and by extension at UCT). It appears as a hidden culture of bullying, vindictiveness and envy, driven perhaps by a desire to promote conformity, to suppress freedom of speech and expression, and perhaps also to limit efforts at transformation. Some call it The Power of the Anointed (from the book of that same title written in 1995).

I attach an article describing the criminal action of "academic mobbing" (1), the process to which I was subjected by the Faculty after August 2014 following the publication of the letter to the Cape Times from the then Dean and 3 other senior professors. Their letter is also attached (2).

The clear goal of that letter was to destroy my academic legacy using methods described in full in this monograph (3). If the culture of UCT and of the Faculty was truly the promotion of freedom of expression allied to sensitivity (and empathy) and freedom from the covert influences of commercial interests, the letter could never have been written. That its' publication was not challenged nor repudiated by either the senior management of UCT or of the Faculty, confirms what may be the real "culture" in these institutions.

As described in detail in *Lore of Nutrition/Real Food on Trial*, just one lonely person in the Faculty, the late Emeritus Professor Max Klein, took the trouble to complain to the

then Dean. His complaint was ignored. It's as if, as far as UCT and the Faculty are concerned, the 4 Professors' letter was never published and the academic mobbing never occurred.

The point is that the Faculty and the senior management at UCT completely failed me, my wife and my family. Just as they have since failed Professor Mayosi, his wife and his family. Thus one might suggest that one feature of the "culture" of this Faculty is an absence of REAL concern for the well-being of its individual members. It's simply every man and woman for him- and herself. With no unified vision of what constitutes a desirable "culture".

A not uncommon outcome of the academic mobbing that happened to me, is that the targeted victim commits suicide. I chose, at great cost and with remarkable support from my wife, the general public and two astonishing lawyers (who understand the importance of freedom of expression as a fundamental academic right that must be protected), to fight the system rather than to commit suicide. Under different circumstances I might have been just another suicide statistic in the dark side of this Faculty's history.

As you are aware this academic mobbing of persons associated with me in the Unit of which I was the former Director for 25 years, has not ceased since I retired. This is predictable because once academic mobbing begins, those closest to its targeted victim must prove to the mobbing crowd that they are the strongest repudiators of that victim.

My point is that unless this toxic sub-culture in the Faculty is addressed, the Faculty is likely destined to become progressively more crippled and second-rate, regardless of how it appears on the outside to those who don't understand what's going on "inside". Which good people want to work in a culture that is so evidently toxic? Ultimately a toxic culture drives out all the good people. It commits fratricide.

To change the culture, one cannot paper over the cracks with lofty words and pronunciations of being a world-class, research-led institution – "the best in Africa". One needs a very different approach.

The challenge for the Faculty is to develop a culture that is worth fighting for. In team sports one does this by employing a team (of managers and players) who know the type of culture that is desired and one appoints a captain who have the skills to produce and sustain that culture (4). Most importantly they have the desire to fight (and in sporting terms, to die) for that culture.

Without this, the future of the Faculty (and the University) is predictable.

2. UCT's teaching of nutrition and dietetics continues to ignore the evidence-based information I presented at my HPCSA trial (and which was accepted as the truth).

I gather that on the day he took his life, Professor Bongani Mayosi was about to address the fact that I had won my case before the HPCSA and had proved that the low carbohydrate, healthy fat (LCHF) diet is indeed evidence-based; it is not a dangerous "fad diet"; and can (and should) be considered an option for the treatment of persons

with insulin resistance. That is what my trial established in legal terms that now apply around the world.

I also gather that in conversations with other international colleagues, when challenged, Professor Mayosi had explained that: “It (Noakes’ difference with the Faculty) was never about the diet anyway”.

Logically I assumed that having taken 4 and a half years to prove my point in court and at the cost of so much money to myself and the HPCSA, the Faculty would adopt this new truth.

Instead to my knowledge, nothing has happened as yet. And perhaps with the passing of Professor Mayosi, there is no longer any incentive for this change to happen.

It is perhaps pertinent to emphasize that senior members of the UCT Division of Nutrition and Dietetics worked tirelessly with the Prosecution in my HPCSA trial in their attempt to ensure that I was found guilty of the charges.

Perhaps I could ask the Faculty to investigate the following: Was my “matter” on the agenda of the Faculty’s Senior Management committee meeting scheduled for the Friday on which Professor Mayosi passed. If so, has it or will it be addressed in subsequent meetings of that committee?

Perhaps the Faculty and UCT need to ponder the question: If the UCT Division of Nutrition and Dietetics continues to ignore information that is clearly important to their clients’ long term health, are they not guilty of doing harm (by omission)? Which conflicts with the Hippocratic Oath all students take and which specifically warns: First do no harm.

How will the University and the Faculty defend itself when those who have been harmed by incorrect advice seek redress as seems possible sometime in the near future?

3. UCT Medical Students are not being taught key materials that will ensure they can effectively weather the massive change in medical practice that is about to happen

What I have really fought for these past 8 years is to promote the understanding that insulin resistance is the most prevalent medical condition across the globe, outstripping the importance of any other diseases or groups of diseases. A paper published this month shows that 88% of North Americans do not have a healthy metabolism because they have features of the insulin resistance syndrome (5). Their future health requires that they eat a diet that will prevent them from developing chronic conditions, brought about by their level of insulin resistance.

Some key information I presented in my Trial is that insulin resistance is the underlying biological basis for a range of chronic diseases including, amongst others, obesity, hypertension, type 2 diabetes mellitus, gout, osteoarthritis, osteoporosis, polycystic ovarian syndrome (PCOS), acne, dementia and Alzheimer’s disease (also called type 3 diabetes) and perhaps also some forms of cancer.

If this is true, then the pharmacological approach to these chronic diseases that we (and the rest of the world's medical faculties) teach, is likely to be incomplete. Because if these diseases have a nutritional basis, then it makes no sense to treat them with life-long pharmacological drugs that do not address the real (nutritional) cause.

A reality with which the Faculty needs to grapple is that social media and the ease with which the general public can now access medical information, is irrevocably changing certain aspects of the practice of medicine. In particular, social media is spreading the message (virally) that medical conditions (like type 2 diabetes) that can be "reversed" by dietary change and without the need for a medical prescription, can also be treated successfully by others who practise outside the medical profession.

Thus I predict that in the near future, the chronic management of some of these specific conditions will be provided by "patients" (who have "cured" themselves) and who will advise other "patients", probably via the internet.

Alternatively they will be managed by companies like VirtaHealth (6) that, having successfully begun its' quest to "reverse type 2 diabetes in 100 million patients by 2025", will in time become the Amazon.com of future medical care.

When I have the privilege of lecturing our medical students, I make the point that they need to prepare themselves for this reality whether or not the Faculty can foresee this future.

Another factor that will expedite change is the development of cheap continuous (blood) glucose monitors worn as a wrist watch. Once these devices become widely available, they will reveal just how common are continuously elevated blood glucose concentrations in the general public (and in members of the Faculty!) if they eat the modern industrial "low fat, heart-healthy diet, in moderation" that is promoted by the UCT Division of Nutrition and Dietetics. Continuously elevated blood glucose concentrations is a key marker of the insulin resistance syndrome – and a diet that is too high in carbohydrates.

But perhaps more importantly, because we have failed to prevent the obesity/diabetes epidemic, in 10 years' time there will simply be no money left in the health budget to treat conditions other than diabetes and its related conditions; all caused by high carbohydrate diets eaten by those with insulin resistance.

Would it not be really exciting for UCT and the Faculty, to promote a nutritional intervention within Cape Town (the diabetes capitol of South Africa) and South Africa that actually works and has been proven (even by researchers within the Faculty) to have the potential to "reverse" type 2 diabetes (when properly adopted)?

Or are we too proud to acknowledge our errors? And too scared to risk being called "unconventional"?

Interestingly on 18th December 2018, the America Diabetes Association (ADA) has released its newest (2018) Guidelines for the management of type 2 diabetes (7). The European Association for the Study of Diabetes (EASD) has also recently released its own guidelines (8).

The new guidelines amongst others state that:

"***low carbohydrate eating plans may result in improved glycemia and have the potential to reduce antihyperglycemic medications***";

"***Reducing overall carbohydrate intake for individuals with diabetes has demonstrated the most evidence for improving glycemia…***"; and

"***reducing overall carbohydrate intake with low- or very low-carbohydrate eating plans is a viable approach***".

It is now of some historical interest that in 2013 in our book *The Real Meal Revolution* – the publication that incited the Faculty to intensify its mobbing of me, beginning in 2012 – I wrote the following:

"***But perhaps more important is the idea that insulin resistance (IR) is the hidden metabolic abnormality underlying many of the chronic diseases reaching epidemic proportions in modern humans and which includes obesity, type 2 diabetes, high blood pressure, high blood cholesterol concentrations and heart disease".***

"Perhaps the reason why these diseases are now reaching epidemic proportions in all populations eating highly processed carbohydrate-rich foods is because those are the exact foods that those with IR are the least able to metabolize safely".

"The evidence that Banting (the low carbohydrate high fat diet) produced the greatest benefits in those who are the most ill…is in line with this evidence and neatly destroys the prejudice that a high fat diet is a dangerous 'fad'. Instead the logical conclusion must be that Banting is the safer option for those who are the most ill because they have morbid obesity, diabetes, hypertension or hypercholesterolaemia as a result of more severe IR".

"Thus the evidence suggests that the 'healthy' HCLF (high carbohydrate low fat) diet will be much less effective in preventing future heart attacks than Banting and more especially in those with more severe degrees of IR".

Contrast my 2013 statement and that of the 2018 American Diabetes Association with the scientifically unsupported statement of the 4 Professors letter to the Cape Times in August 2014 (2): ***"there is good reason for concern that this (LCHF/Banting) diet may rather result in nutritional deficiencies, increased risk for heart disease, diabetes mellitus, kidney problems, constipation, certain cancers…"***. Predictably the 4 Professors provide no scientific support for these statements.

The Cognitive Dissonance in this statement is astonishing even for the most biased observers. For every day these 4 Professors are faced with a tsunami of patients at Groote Schuur hospital presenting with heart disease, diabetes mellitus, kidney problems and cancers. According to the Professors' logic all those patients must be eating the low carbohydrate high fat "fad" Banting diet.

Yet we know that ill Capetonians are not eating that diet. They are eating high carbohydrate diets that are driving them to develop all the medical conditions linked to IR (9).

4. By not embracing this new information, the Faculty is denying itself the chance of making significant important research discoveries in the near future.

When I discovered the value of the LCHF diet and began to write about it, I presumed that a reputedly "research-led" University like UCT and this Faculty would embrace these new ideas as an opportunity to do something really innovative to reverse the coming obesity/type 2 diabetes tsunami.

Instead as we describe in *Lore of Nutrition/Real Food on Trial,* my trial suggests that the academic influence of the Faculty was unleashed specifically to ensure that these novel ideas would never be tested or even considered.

Now that I have won my case, perhaps the Faculty should consider the following evidence, discussed next. And become prepared to answer the question: ***If we are not exploring these research opportunities, then why not?***

Over the past 8 years I have focused all my academic attention on nutrition and its effects on our health. I conclude that a wide range of chronic diseases can be "reversed" by changing from the current diet of highly processed foods to one we have termed in our books as "real foods". My certainty in this matter is re-enforced by the daily feedback I receive on social media – the final retreat for patients who wish to share their often extra-ordinary (anecdotal) stories of disease "reversal" as a result of following the LCHF eating plan.

From all this evidence (which includes clinical trials and published case studies, besides anecdotal reports) I suggest the following conditions respond quite remarkable to this change in diet:

Cardiovascular conditions.

One of the key reasons I was targeted by the Faculty was because I have pointed out that, because it is the immediate cause of type 2 diabetes, the low fat, high carbohydrate "heart healthy" diet has perversely produced an epidemic of disseminated obstructive arterial disease, the key pathology in type 2 diabetes. No one has yet presented any evidence that I am wrong.

My point is that there is no evidence that the "heart healthy" diet promoted by the UCT Division of Nutrition and Dietetics is heart healthy. So there is at least the possibility that its polar opposite, the LCHF diet – the diet that most humans in "developed" countries were eating before the 1970s – may in fact be more likely to promote healthy arteries and hearts.

The point is that this would be a wonderful opportunity for the Faculty to make a global contribution to an extra-ordinarily important and contentious topic. From what I have read, I would suggest that Vitamin K2, added to the LCHF diet, needs to be researched as a potential supplement for improving arterial health.

Another simple study that has yet to be done (even though numerous units around the world already have the data but are seemingly reluctant to do the analysis – for obvious reasons!) is to correlate (i) blood cholesterol concentrations and (ii) markers of insulin resistance, with the extent of coronary artery disease in those with and without established coronary artery disease. The prediction is that blood cholesterol

concentrations will not, whereas markers of insulin resistance will, predict the extent of coronary artery disease.

One point I am more certain about is that **Arterial Hypertension** is strongly linked to insulin resistance and a diet that is high in sugar and carbohydrates. As part of my (Noakes) Foundations' Eat Better South Africa campaign in 10 disadvantaged communities in the Western Cape, we have seen remarkable reductions in blood pressure in response to removal of sugar and excess carbohydrates from the diets of members of these communities. So encouraging are these findings that we are funding a large RCT, one goal of which is to study the effects of this dietary change on blood pressures in the study participants. If this proves effective, it will be a novel finding. The question of course is: Why has this never been tested before? Why is the proven link between insulin resistance and hypertension not acknowledged in this Faculty?

Adjunct to cancer therapy especially chemotherapy

Since a number of cancers are dependent on glucose for their energy metabolism (The Warburg Effect – Nobel Prize in Medicine 1931), some suggest that a high fat ketogenic diet may be of some value in treatment of this condition. Despite significant resistance to this concept from oncologists, the idea has gathered enough global support for there to be 32 clinical trials ongoing at present of the use of this diet as an adjunct to cancer chemotherapy. The feedback I receive from patients is that the side-effects of chemotherapy are less when on this diet and recovery is quicker.

Dermatological conditions.

Acne is disease of the modern diet and does not occur in persons eating their traditional foods (before the arrival of the "diet of modern commerce").

I have numerous reports of persons with **psoriasis** or **eczema** that heals completely once they adopt this diet. There are no RCTs of which I am aware. Thus the possibility for the organization of such trials within the Faculty.

Gastrointestinal conditions.

A number of clinical trials show that **Gastro-Oesophageal Reflux Disease (GERD**) is cured by the LCHF diet and the mechanisms are understood. I would guess that this is one of the commoner conditions treated at Groote Schuur Hospital.

A range of auto-immune diseases of the small and large bowel (**Crohns' Disease; Ulcerative Colitis**) may be caused by either chemicals present in specific plants or even in some constituents of processed foods like carrageenan. Thus a growing number of anecdotal reports describe complete resolution of these conditions in **some** persons who avoid all plants (vegetables) and processed foods eating a purely carnivorous (meat-based) diet. My point is that it would not take a great deal of research effort (or cost) to attempt to disprove this theory. More importantly one cannot predict where it would end if it was found that a diet change can indeed cure some of these conditions.

Leaky-gut syndrome. There is clear evidence that gluten/gliadin (or related proteins in wheat, barley and rye) increase gut zonulin concentrations which then opens up the gap junctions between enterocytes, allowing the passage of antigenic proteins into the portal

vein. Professor Alessio Fasano (Harvard Medical School) argues that this may be the cause of a number of conditions including the auto-immune conditions.

The point is that there is little cost in conducting exploratory studies to see if there is any possible truth in these speculations. In my opinion we should be exploring them.

Metabolic conditions.

Type 2 diabetes and the **metabolic syndrome** can be "reversed" by an LCHF diet that is suitably low in carbohydrate (<25g/day). This is now incontestable (5). The proof is provided by multiple RCTs (randomized controlled trials).

Obesity is, in my opinion, best managed on an LCHF diet because it is the only eating plan that prevents the development of "starvation psychosis" (as described in *Lore of Nutrition/Real Food on Trial*). Ultimately obesity is a disease of "hunger" and without control of the hunger mechanism, it cannot be reversed or prevented.

Neurological conditions.

The ketogenic version of the LCHF diet is an accepted treatment for epilepsy.

There is growing interest in the prescription of this diet for those recovering from traumatic brain injuries, especially concussion.

Some forms of brain cancers seem to respond unexpectedly well to this diet.

There is also interest in the role of this diet in managing persons with diverse psychiatric conditions including **depression**, **autism** and **bipolar disorder**.

Obstetrical conditions.

Six years ago when The Real Meal Revolution was first published, the general public in South Africa had no idea what the term "Banting" meant. Today Cape Town hosts a Banting 7-Day Meal Plan Facebook page that has a membership in excess of 1.5 million; 80% of whom are Xhosa- or Zulu-speaking South Africans. This gives an idea of the degree to which this eating plan has penetrated the South African conscience.

The benefit most frequently reported by women on this site is that they have reversed their **infertility**since adopting this diet (and as a result have been able to conceive). It appears that for susceptible women, often with insulin-resistance PCOS, the increased intake of dietary fat is all that is required to normalize their fertility.

Orthopaedic conditions.

Osteoporosis is increasingly being described as a condition linked to insulin-resistance and a nutritional deficiency of Vitamin D3 and K2, typically deficient in high carbohydrate, low fat grain-based diets. It would not require much to initiate studies of the potential roles that insulin resistance and an inadequate diet make to the development of osteoporosis.

Paediatric conditions.

The fake reason that the HPCSA used to charge me with unprofessional conduct was a tweet related to the weaning of infants. My tweet was fully compatible with the South African Dietary Guidelines as they relate to complementary feeding of infants. One reason I was charged was because I failed to mention cereals and grains, and this caused those and other industries to desire my scalp.

But the reality is that the majority of South African children are weaned onto nutrient poor high carbohydrate, grain-based foods that leave them **stunted** and **malnourished**. Their malnutrition is because they are not receiving sufficient animal foods. The evidence that animal foods prevent stunting (and the related condition, anaemia) is crystal clear.

Yet why does the Faculty not take a stand on this matter? I suspect the answer is relatively simple.

There is also growing evidence that mothers who eat high carbohydrate diets during pregnancy produce babies that are fatter and at greater risk of developing **childhood obesity** and perhaps early onset type 2 diabetes. Again an ideal topic for the Faculty to study if we wish to limit the rise in childhood obesity.

Other conditions.

This list is far from complete but for the purposes of this email, I think the point is made.

5. Lore of Nutrition/Real Food on Trial.

No one who was not present during the 28 days of my HPCSA trial can ever appreciate the adversarial nature of that trial and the viciousness to which I was subjected.

I wrote the book *Lore of Nutrition/Real Food on Trial* with investigative journalist Marika Sboros to record for posterity exactly what happened to me before and during the trial and the contribution that various academic colleagues made to ensure that I would be prosecuted. In the history of science, it is a landmark event.

Anyone who wishes properly to understand our side of these events needs to read this book.

6. Conclusion.

In closing I include a link to a trailer to a documentary that includes reference to my trial https://www.youtube.com/watch?v=61GitUC_678.

The documentary has been viewed by millions already (on Netflix). The documentary also shows where the future for the prevention of the chronic diseases I have discussed, is heading.

It would be a pity if the Faculty that has been so central in taking this LCHF diet message globally (certainly more by error than by intent) should be left behind by what must inevitably happen in the very near future.

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